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DEPARTMENT OF PUBLIC WELFARE

TO: Mr. Morris Hursh, Commissioner — April 4, 1968

DPW Cabinet

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Attention: Medical Directors
Administrators

Community Mental Health Programs
Attention: Board Chairmen
Program Directors

Daytime Activity Centers
Attention: Board Chairmen
Program Directors

Field Services Division Personnel

The Honorable Harold LeVander, Governor
Attention: Mr. Wallace R. Hoaglund

The Honorable Douglas Head, Attorney General

Mr. Bruce Okney

FROM: David J. Vail, M. D.
Medical Director

SUBJECT: Mental Health and Mental Retardation Programs in Rural America

Attached is a copy of my article "Mental Health and Mental Retardation Programs in Rural America" delivered at a conference in Phoenix, Arizona, on April 3, 1965. The conference is entitled "Mental Health Services to Sparsely Populated Rural Areas."

I thank all of you who sent in suggestions on the theme. In a separate section on acknowledgements I have listed respondents by name, and I hope I have not omitted anyone. In the excerpts used in the article I chose not to credit sources by name.

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DJV:rcj

MENTAL HEALTH AND MENTAL RETARDATION PROGRAMS IN RURAL AMERICA[1]

By

David J. Vail, M. D. [2,3]

I am very much pleased and honored to have been asked to participate in this conference, the more so as I have been asked to deliver this keynote address. I hope in doing so I can effectively meet the expectations of the program committee and of my good colleague, Dr. Myrick W. Pullen, Jr., the conference chairman, who was so kind as to invite me to take on this interesting and I may honestly say enjoyable task.

I have entitled my talk "Mental Health and Mental Retardation Programs in Rural America." I will shortly state the reasons why I have chosen this particular title and will define the various components of it.

The paper is divided into five sections:

I. Definitions

II. Programs

III. Tactics

IV. Culture

V. Overriding Concerns

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[1] Keynote address presented at a conference entitled "Mental Health Services to Sparsely Populated Rural Areas." Phoenix, Arizona, April 2-5, 1968

[2] Medical Director, Department of Public Welfare, State of Minnesota

[3] From the Department of Public Welfare, State of Minnesota

I. Definitions

(1) Programs and Service

I have deliberately chosen to emphasize "programs" rather than "services" because I think there is a very vital and fundamental difference. I think the difference is often overlooked, as the terms are often used synonymously. Furthermore, the whole idea and semantics of "service" are unsatisfactory. Finally, I think that the service model as it is used these days contains many serious and indeed self-defeating faults.

The etymology of program means that which is written out ahead of time. It connotes a deliberateness, a formal and organized intent, a plan of action. It must, it seems to me, include a written document that is prepared in advance or else it cannot truly be called a program. The concept of program is inseparable from that of system, which is a working of interrelated parts towards the achievement of specific goals according to some pre-arranged scheme. The program is, so to say, the instructions given to the system, so that the system will operate in some organized way to achieve program goals.

Another interesting and valid use of program is the actual phenomenology of events that occur in accordance with the previous arrangements. Thus the program of a musical concert is the written

document prepared ahead of time, which instructs the orchestra what to play and notifies the audience what to expect. The program is also the music itself as experienced by the participant players and listeners.[4]

One of the defects of the service model is that it may not lend itself too readily to program. If there is no plan, or if the original plan has broken down, we comfort ourselves by providing more services -- more of the same, or sometimes new services. We make it up as we go along.

The program calls for an organized array of actions aimed at some clearly explicit goal. Measureable objectives are determined and ways of attaining those objectives are stated. Choices are

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[4] An interesting deviation from the classical duality of the program concept as I have just defined it is the situation where a group is called together by prearrangement for a stated purpose, but there is no plan to the events. The paradigm for this experience is the Quaker meeting, where the participants sit in silence, to speak as the spirit moves them. (This is paralleled in the larger life scene by the marvelous Quaker phrase "to proceed as the way clears.") By my definition such a course of events cannot be called a program, for there is no plan to it. Rather it is a happening; and this is a good word, for again etymologically "happen" refers to chance befallment. The Quaker meeting is a valid counter to organized denominational religious practice and improvisational music is a valid counter to that which is prearranged note by note; and in like manner the "happening" in art and in life is a valid counter to an over-abundance of pre-arrangement and conformity; program and happening are antithetical. The whole idea of the happening is to get away from program, and individuals and societies must do this from time to time.

provided, so that if one way of reaching the objective is impossible or is too costly, some other way can be taken. The progress of reaching the objectives is charted and altered as necessary, again by deliberation and design, not by a spontaneous or random process of "let's try this and see if it works."

What are the actions undertaken in the program? Understandably such actions may include "services." Here we come up against the etymology of "services." If all program actions are defined as services, then we are bogged down in an impossible semantic circle. Thus a program to reduce malaria in a given community may well include spraying ponds with insecticides, as well as giving atabrine (a preventative drug) and/or quinine (a pellative drug) to the sufferers. The giving of drugs may be interpreted as a "service" but I submit that spraying ponds should not be categorized as a "service" as this term is ordinarily used.

We have found in Minnesota after many years of hard labor that the program goals must be reduced to a definitive set of problems that must then be overcome. That is, we assume that a state of perfection does not exist, and that the reason for this is that certain problems intervene between the actual state and the perfect state. Thus goal and problem are interwoven, and we then speak of problem-goals. The program is the arranged set of activities undertaken to

reduce the problems so that a state of perfection can be approximated and hopefully arrived at.

"Services" may be included in this set of activities, but as the term is commonly used it refers to things done by certain persons ("providers of service") in relation to certain other persons ("consumers of service"). If the service concept becomes all-inclusive to mean anything that is done to overcome a problem, then it loses meaning. If, in contrast, it becomes elastic, and can be used to include now one thing and now another, then the situation is even worse and terrible contradictions and distortions can arise.

(2) Service

What is "service"? What is "a service"?

The word service, of course, derives from the verb to serve. Serve is a transitive verb par excellence and is one of the greatest available examples of a word that has become, so to speak, "intransitized."

The dilemma is outlined in this old but basic joke:

Customer: Do you serve women at the bar?

Bartender: No, you have to bring your own.

The point of the joke is that the direct and indirect objects of serve have been confused. Alas, in our line of work, the situation is even worse, as the direct and indirect objects may not only be confused, but omitted altogether. This is accentuated by the degradation of the verb to serve into the noun service. "Service" when used alone, as when we talk of "providing service" may omit the following vital factors:

-- who is serving?

-- who is being served?

-- what is being served?

-- how is it being served?

-- why is it being served?

Internal to the above questions, so to speak, is the additional question of quality: What is the nature and the good of that which is being served, as it will affect both the servor and servee? Possibly this question is contained in why?

The service model often slides by such questions. Our view is that unless the subjects and direct and indirect objects of service, and the purposes (stated in problem-goals) are clearly explicated and organized in a program we are in danger of sinking into a dangerous and wasteful circularity.

The term "quality services" is totally inadequate and -- worse -- misleading. For it begs the basic questions about services and postulates that "more," "better," "professionally validated" services will be better than just ordinary services. In other words, it accentuates input rather than output. The entire service model, in fact, is an input model. The "output" of the service is really an input directed against the problem toward which the service was intended. It is the impact that counts, and the service model really doesn't cope with impact. Thus, providing service becomes an end in itself and the service often carries on regardless.

Several things are done with service, that is, there are several ways of serving. Ranging from passive to active in tone, they are:

(1) Service is made available.

(2) Service is offered.

(3) Service is provided.

(4) Service is delivered.

The last-named, the delivery of service, is probably the most pertinent to the theme of this conference. For the less active voices will not suffice in a situation where distance, economics, and attitudes hinder efforts to solve problems, and an active approach is needed.

(2) Mental health and mental retardation

I prefer the dual usage of mental health-mental retardation, in which the problem of mental retardation is specifically stated, for various reasons, among them its usefulness to our programming in Minnesota.[5] I think it is important if we are to maintain a proper breadth of program. The issues affecting program development in rural areas will in any event be pretty much the same for mental retardation as for any other health problem.

(3) Population density

What is a "sparsely-populated rural area"? This is indeed a fascinating and perplexing question. A look into it is very puzzling, but it reveals at least the diversity of this great land of ours.

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[5] "Mental health and mental retardation" is an accustomed grouping, though an unsatisfactory one. For mental retardation is a problem and a legitimate one which the system should organize itself to attack. "Mental health" on the other hand is a general field. It is both a shorthand and a reversal. Operationally it means, or should mean, an effort to overcome a group of problems that interfere with or are the opposite of mental health; mental illness, inebriacy, suicide, etc. The reason for the usage mental health and mental retardation is that if we do not do this mental retardation is lost sight of as one of the principal problems to be dealt with. In the business it is usual to say that "mental health problems" includes mental retardation but in actual practice it does not work this way. It seems to me that unless we explicate mental retardation and grant it this kind of emphasis, it continues to take a secondary role in the total effort. Including mental retardation complicates the problems we are here to discuss, but it is in my opinion necessary.

Let us look first at population density figures. The U.S. as a whole has a population density of 55 persons per square mile. Among the 50 states density ranges from 916 pers./sq.mi. for New Jersey (approaching the density of an average U. S. metropolitan area) down to 0.386 pers./sq.mi. for Alaska, something on the order of 1/2400 of the New Jersey figure.[6] The states west of the Mississippi River (excluding Alaska) range from 121 pers./sq.mi. in California to figures of less than 10 for the northern prairie and mountain states (save Colorado, Arizona, and Utah), ranging down to 3 for Wyoming.

Minnesota, with a density ratio of 45, is relatively crowded and isn't in the same league with the mountain states. But Minnesota illustrates the fact that if we look within a given state the picture becomes more complex. For in Minnesota almost exactly half the population is clustered in seven metropolitan counties surrounding Minneapolis and St. Paul. Among other things this means that state-level planners have to be equally expert in urban and rural matters. It also means of course that the remainder of the state could be fairly thought of as "sparsely populated."

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[6] The figures shown are official 1966 figures from the U. S. Bureau of the Census. I do not have figures available for population density in the Trust Territory of the Pacific Islands, which is eligible for mental health funds under 314d as of July 1, 1968. The population density of the District of Columbia is 13,246 pers./sq.mi., an urban density figure.

I am not sure what might come out of further studies in this field. If we could develop precise measures of program impact, then it would be interesting to relate them to population density. As it is, for our purposes here, I think we could consider a population density of less than 20 pers./sq.mi. as being sparse, and anything less than 10 as extremely so.[7]

I am not sure it makes much difference where we draw the line or what constitutes "sparse" or "dense" provided that we are clear among ourselves on the definitions for purposes of communication. These are relative matters, often highly personal; probably each person carries with him an unconscious or semiconscious set as to what is a comfortable population density, based among other things on his experience and what he is used to; and he will thereby respond to a place as being more or less "crowded" or "lonely."

(4) Urban vs. rural

Here again matters are relative, and the definitions not as easy as they look. The U. S. Census Bureau regards a city as an incorporated place of 2500 population or more, and that will do for our purposes. In Iceland, according to the Encyclopedia Brittanica (1957 ed.) "urban" means a settlement containing 300

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[7] Hawaii is hard to categorize. For on the basis of population in relation to actual land area it has a density of around 112 pers./sq.mi., about on a par with California. But its insular character of course poses particular problems in transportation and communication.

or more persons, while in the Netherlands a community must contain a population of at least 20,000 persons before it qualifies as urban.

Where it gets interesting is in the relationship between a town or small city in a rural area, and the area that surrounds it. There are different social and economic forces that operate in town and country and the resulting situation has a bearing on the tactical issues to be discussed in Section III.

It is also extremely important to bear in mind that rural areas may differ markedly from one another in their social and political complexion, based on the economics of the area. Furthermore, the incidence of psychosocial disorders has been shown to vary in relation to the affluence of rural areas. In a Minnesota study, for example, rates of major mental illness were significantly higher for poor rural counties than for rich rural, metropolitan, and suburban counties.[8] It was our conclusion that ". . . the socio-economic level of the area would be the factor related to major mental illness -- not urban or rural status."[9]

Based upon this and other studies and on general experience, I would go so far as to say that economics is the critical issue in

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[8] Vail, et al (see bibliography). In this study "major mental illness" was defined as follows: ". . . first admissions to state hospitals (incidence), readmission, and in hospital population (prevalence) and all discharges." (Op.Cit., p.212)

[9] Ibid, p. 212

mental health-mental retardation programming for rural areas. For the measures necessary to overcome the problems of distance and other effects of sparse population cost money. At the more basic level at which cases are identified and remedies are attempted, especially the search for solutions other than state hospital placement, it is my impression that the general economics of the area has quite a pronounced effect on program activities. That is, the range of options and the freedom of choice by or on behalf of persons with mental disorders seems to vary in direct relationship to the affluence of the area.[10] We return to this theme later in relation to culture.

II. Program

We have heard a great deal about the "five essential services" of the federal-style community mental health center.

How about the five essential elements of program (and remember that I am talking about a comprehensive community-based mental health-mental retardation program.)

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[10] This problem is striking in Minnesota, where mental hospital regions may vary markedly in their affluence. The program of the Rochester State Hospital, serving a wealthy rural region, is quite different from that at Moose Lake State Hospital or Fergus Falls State Hospital, which serve mixed and in some parts extremely poor areas. Though it is almost impossible to substantiate, one has the impression also that the actual clinical psychopathology dealt with is different among the various rural regions, both in relation to each other and in relation to the metropolitan region.

Here are principles we have derived on this basis of many years of experience in Minnesota. We have come to regard these as anxious, as self-evident truths, that apply universally whether we are talking about rural areas, urban areas, or something in between:[11]

(1) There must be a rational ordering of the wide range of personal and social problems to be dealt with.

(2) There must be in a truly comprehensive program a differentiation between the public program, charged with primary responsibility for the problems of public concern, and non-public programs that have a broad, flexible, and so to say self-determining responsibility for the range of problems that are not necessarily of public concern.

(3) There must be a mandated local public agency to carry out the public program at the local level.

(4) There must be a local agency which takes responsibility for comprehensive program design planning, implementation, and evaluation; that also takes into account the entire range of public and non-public programs. It is very hard to see how such an agency could function properly without some statutory base of authority.

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[11] The remainder of this section is taken almost verbatim from commentary on William Ryan's monograph Distress in the City (see bibliography).

(5) The state agency must concern itself with the entire range of programs, public and non-public. Though the manifestations of this concern vary it is hard to see how it could be effectively expressed without some statutorily defined relationship between the state agency and the local agencies in their respective roles of authority and responsibility.

Let us take up these points in turn:

(1) A rational ordering of problems

After several years of study, we evolved the following scheme for ordering the broad range of problems we deal with under the broad rubric of mental health and mental retardation.

I. Statutorily defined problems

A. Statutorily-defined mental problems

> There are problems defined by law. They are of sufficient concern to the public that laws are devised to not only define them, but to lay down the ways in which they are to be dealt with. The law furthermore makes government agencies responsible for them and ascribes to these agencies an inescapable accountability for preventing and reducing the problems. This is the province of public mental health, where that phrase connotes the same kind of public responsibility and accountability as is found in the public health field generally.
>
> Statutorily defined mental problems in Minnesota, with the inauguration of a new hospitalization and commitment law in 1968, are as follows:

(1) Mentally ill person (additional variants: mentally ill and dangerous, sexual offender, psychopathic personality).

(2) Mentally deficient person.

(3) Inebriate person.

B. Mental and emotional aspects of other statutorily defined problems.

Examples: Crime, juvenile delinquency, child neglect, school dropout, etc. That is, the variety of psychosocial problems that are defined by law and accorded a legal status upon some official event such as a conviction, adjudication, court ruling, or agency action.

II. Culturally defined problems

Here the culture, the community, judges that "something is wrong" or "something ought to be done." Services may be available and offered, or pressures applied to get problematic persons to receive the service. There are however no formal legal categories or mechanisms for dealing with the problems. One of the pressures, of course, may be the threat of legal action.

A. Culturally defined mental problems

Examples: Suicide attempts, mental retardation (differentiated from mental deficiency, which is defined statutorily), suspected and diagnosed psychiatric disorders, impulsive and/or hostile behavior, etc.

B. Mental and emotional aspects of other culturally defined problems

Examples: Marital disharmony, unemployment, under-achievement, etc.

III. Individually defined problems

Here the individual determines his own status, usually on the basis of some subjective discomfort.

A. Individually defined mental problems

Examples: Anxiety, phobias, feelings of inadequacy, etc.

B. Mental and emotional aspects of other individually-defined problems

Examples: Sexual frigidity or impotency, somatic symptoms, work dissatisfactions, child rearing problems, etc.

(2) Public and non-public programs

A truly comprehensive mental health-mental retardation program must concern itself with the entire range of the problems listed above. Obviously this is hard work, especially when it comes to making priorities and devising appropriate methodologies.

In the Minnesota scheme, items IA and IB above, that is the categories of statutorily defined problems, are the responsibility of the public mental health-mental retardation program. This is represented at the state level by the Department of Public Welfare, at the regional level by the state hospitals for the mentally ill and mentally retarded, and at the county level by the county welfare boards and departments. These agencies have mandated basic responsibilities under Minnesota law.

At the same time comprehensive mental health-mental retardation program responsibility is allocated another way. It rests with the Department of Public Welfare at the state level, to be sure, but thence flows not to

county welfare boards but rather to the community mental health-mental retardation boards established under the 1957 Minnesota Community Mental Health Services Act.

While the public program is mediated locally by counties, the comprehensive program is mediated by areas. In Minnesota the area is defined as the county, group of counties, or (in one case) part of a county served by a community mental health center; that is, under the jurisdiction of the community mental health-mental retardation board. In some cases, the area and county coincide. More often, the area comprises a group of counties. In the state generally there are 87 counties, sorted in 25 areas, of which 23 have formally organized mental health-mental retardation boards. In the rural parts multiple-county areas are the general rule.

There is between the public program and the comprehensive program a difference in the kind of responsibility that is involved. The county welfare board has <u>direct</u> responsibility for the public program. The area board, on the other hand, has no direct jurisdiction over the county or over anything else save the mental health center or such other program as it may operate directly. But it has an encompassing duty to provide total program guidance, design, development, coordination, implementation and evaluation; and the fostering of resources and expertise as to the allocation of available professional skills and services.

A good example of the county welfare board-mental health-mental retardation board relationship is seen in the Minnesota Hospitalization and Commitment Act, taking effect on January 1, 1968. Under Section 10 of this statute counties must provide "places of temporary hospitalization" (or "public health facilities") where persons may be detained for "observation, evaluation, diagnosis, treatment and care" pending commitment hearings. The county welfare board is charged to "assure proper care and treatment" at such facilities. Thus the legal mandate in this instance is clearly related to the public agency (county welfare board) at the local level; at the same time the state looks to the area mental health-mental retardation board to oversee the development and implementation of these programs within its county or group of counties, and the state calls on the area board to be responsible for organizing and/or providing training, consultation or other services necessary to make this particular feature of the county public mental health-mental retardation program a functioning reality.

(3) Mandated local public agency

Our studies suggest that the necessity for establishing a local public agency with mandated responsibilities in mental health and mental retardation is quite weakly developed as a general rule in other places. In Britain the responsibility falls to the local authority, which through local health departments maintains a cadre of "Mental Welfare Officers" to carry it out; in practice overall continuity of responsibility is often de facto carried by the mental hospital. A very highly-developed system of local

responsibility is found in The Netherlands, where the local authorities (historically for mainly financial reasons) maintain control of each individual case through all phases of service, including in-patient care.

In Minnesota the local mandate rests on the county welfare board. This state of affairs is often surprising to non-Minnesotans. Basing their predilections on the so-called "medical model," such persons may express anxiety about the fact that such responsibility is vested in the local welfare not the local health agency. Such a debate is outside the scope of the present discussion; though our view is that the problems of mental health and mental retardation are at least as closely related to the field of welfare as they are that of health and that the wisdom of the Minnesota plan will see its vindication. Be that as it may, the fact remains that a local mandated responsibility does exist. This is the important point. Given that inescapable accountability is assigned by statute to <u>some</u> local agency it is then of secondary importance whether this is given to a specialized mental health agency, to a health agency, to welfare (as in Minnesota), or for that matter to the police. Within the context of the state and local public structure that exists there must be some legislative determination that "the buck stops here." In this sense the non-profit agency, while it may be able to exercise domain in program development, in our view simply cannot be expected to possess the legal authority, by the venerable standards of what goes to make up legal authority, necessary to fulfill the requirements of a mandate for organized public action.

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The legal authority of the Minnesota county welfare board in the mental health-mental retardation field is quite extensive. Two examples will suffice. One is the basic statement of powers and duties contained in Minnesota Statutes 393.07, Subd. 1 and 2 (emphasis added):

"393.07 POWERS, DUTIES. Subdivision 1. Act as county welfare board.

"a. To assist in carrying out the child protection, delinquency prevention and family assistance responsibilities of the state, the county welfare board shall administer a program of social services and financial assistance to be known as the public child welfare program. The public child welfare program shall be supervised by the commissioner of public welfare and administered by the county welfare board in accordance with law and with rules and regulations of the commissioner.

"b. The purpose of the public child welfare program is to assure protection for and financial assistance to children who are confronted with social, physical, or emotional problems requiring such protection and assistance. These problems include, but are not limited to the following:

"(1) Mental, emotional, or physical handicap;

"(2) Illegitimacy, including but not limited to costs of prenatal care, confinement and other care necessary for the protection of a child who will be illegitimate when born;

"(3) Dependency, neglect;

"(4) Delinquency;

"(5) Abuse or rejection of a child by its parents;

"(6) Absence of a parent or guardian able and willing to provide needed care and supervision;

"(7) Need of parents for assistance with child rearing problems, or in placing the child in foster care.

"c. A county welfare board shall make the services of its public child welfare program available as required by law, by the commissioner, or by the courts and shall cooperate with other agencies, public or private, dealing with the problems of children and their parents as provided in this subdivision.

"d. A county welfare board may rent, lease, or purchase property, or in any other way approved by the commissioner, contract with individuals or agencies to provide needed facilities for foster care of children. It may purchase services or child care from only duly authorized individuals, agencies or institutions when in its judgment the needs of a child or his family can best be met in this way.

"Subd. 2. Administration of public welfare. The county welfare board, except as provided in section 393.01, subdivision 3, and subject to the supervision of the commissioner of public welfare, shall administer all forms of public welfare, both for children and adults, responsibility for which now or hereafter may be imposed on the commissioner of public welfare by law, including aid to dependent children, old age assistance, aid to the blind, child welfare services, mental health services, and other public assistance or public welfare services. The duties of the county welfare board shall be performed in accordance with the standards, rules and regulations which may be promulgated by the commissioner of public welfare to achieve the purposes intended by law and in order to comply with the requirements of the federal security act in respect to public assistance and child welfare services, so that the state may qualify for grants-in-aid available under that act. The county welfare board shall supervise wards of the commissioner and, when so designated, act as agent of the commissioner of public welfare in the placement of his wards in adoptive homes or in other foster care facilities."

Another example is taken from the 1967-enacted Minnesota Hospitalization and Commitment Act. This passage puts into law what has been, since 1953, Department of Public Welfare policy. Section 15, Subd. 12 of the Minnesota Hospitalization and Commitment Act reads as follows:

"Prior to the date of discharge, provisional discharge, partial hospitalization, or release of any patient hospitalized under this act, the county welfare board of the county of such patient's residence, in cooperation with the head of the hospital where the patient is hospitalized, the director of the community health center service of said area, and the patient's physician, if notified pursuant to subdivision 14, shall establish a continuing plan of aftercare services for such patient including a plan for medical and psychiatric treatment, nursing care, vocational assistance, and such other aid as the patient shall need. It shall be the duty of such welfare board to supervise and assist such patient in finding employment, suitable shelter, and adequate medical and psychiatric treatment, and to aid in his readjustment to the community."

(4) Local comprehensive program agency

Charged with comprehensive mental health-mental retardation program guidance, design, development, coordination, implementation, and evaluation at the local level there should exist some structure, again with authority and responsibility incumbent on it that is clearly spelled out in statute. While the comprehensive program includes the public program, it includes a great deal more besides. Here is the agency that must assess all the available services in the community, both in public and non-public sectors.

Minnesota law in 1957 established the community mental health-mental retardation boards to be permitted to receive grants-in-aid from the Department of Public Welfare in order to establish local programs of various services aimed at "mental illness, mental retardation, and other psychiatric disabilities." It is this board to which the state has assigned the comprehensive program responsibility at the local level.

(5) State-local relationships

Again, a legal authorization for program development and management is in our view essential. In Minnesota the state agency, the Department of Public Welfare, has the comprehensive responsibility. From here it fans out at the local level to the county welfare boards for the public program and to the community mental health-mental retardation board for the comprehensive program. In both cases a relationship exists between the state and the local agency. In the instance of the county welfare

board, the state-local relationship is supervisory. In the instance of the community mental health-mental retardation board the relationship is contractual.[12]

The point is that a clear relationship must exist, or else there can be no coherent structure to the total program.

All the foregoing program elements can be provided in a rural area. I think that the point relating to the mandated local public mental health-mental retardation agency is especially cogent and relevant to our problem. For the rural area may have no mental health agencies within its borders, it may be miles from a mental health center or the state hospital, it may possess no general hospital facilities to speak of, it may have only one physician to serve several thousand people in a huge radius; but it almost certainly will have a public welfare and/or public health office of some description, for the public law will require this. If all else fails, mental health-mental retardation duties could even be assigned to the county sheriff's department.

The necessity that there be a mandated local agency is the most neglected feature of the comprehensive program (for whatever reasons; these are complex and will include, I believe, professional status factors). In fact, a

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[12] In this context the state hospitals are construed as a service to the area and the county. The relationship between the State Department of Public Welfare and its institutions is a directly administrative one of line authority.

program without this feature is about as "comprehensive" as an army without any infantry. The mandate holds the public agency ultimately accountable for the problem; the mandate also may include the "consumers of service" who may at times be required, as in the instance of a mental illness commitment, to partake of the service.

III. Tactics

Here I divide my comments into three headings: transportation, communications, and manpower.

(1) Transportation

Transportation is a curious and surprisingly difficult problem for us in the human services field in this country. I am not sure of all the reasons for it. There is a peculiar national schizophrenia operating whereby a culture that has on the one hand made a fetish out of the automobile can at the same time be so backward in the policies of its public bodies -- at all levels -- relating to auto or bus travel.

Many instances come to mind. One can think of projects where the key to the entire matter was a mode of transport to get the service consumers to the place where the service was to be provided, but where the simple request in this form did not prevail (again, one suspects professional status factors to be part of the explanation). For years we have tried without success to get the Minnesota state legislature to authorize sharing of consumer travel costs as part of the basic legislation relating

to Daytime Activity Centers for the mentally retarded. And so on: a dreary litany of frustration.

The status of transportation as it relates to the federal-style comprehensive community mental health center is very unclear to me. Along with the general ambivalence of our public people relating to transportation is a more specific defect that stems from the service-center model. That is, the center is a place where service is provided and the consumers are expected to get there. A program focus, on the other hand, may show at once that all the necessary service components exist, and what is needed is a first-class transport system to tie them together and move both the consumers and providers as the situation requires.

Now I have been told "There is money for this" but I have never been told officially and it is nowhere in writing. P.L. 88-164 and P.L. 89-105, we should recall, have to do with construction and staffing of mental health centers, and I am not aware of any mention in them of transportation. In my experience it does not help to be advised to apply for an item like this on a project basis. If there is some solution to the problem that we would not ordinarily know about in the mental health-mental retardation business, such as programs sponsored by the U. S. Department of Transportation, then I would say that the responsibility to help us with this, applying the advocacy principle, rests not with us at the state and local level who are bewildered and terrified by the federal bureaucracy, but with our friends in the Department of Health, Education, and Welfare, who could be expected

to have a fighting chance to locate and obtain the resources; possibly such a suggestion is unfair.

The federal position in an issue like transportation might well be: "The national government is concerned with broad program development; something like this is a state or local responsibility." Unfortunately at the state level one hears "We can't afford a special item like this. Why don't you apply for a federal grant?" So we are back to square one.

It would be better for us not to depend so on federal grants. This is a matter relating to the ways in which public funds are collected and disbursed in this country, and to our national commitments, and it is basically a political issue.

Within the structure of our Minnesota law we have at least been able to underwrite rather handsome travel costs in our more rural mental health-mental retardation areas, and in cases where staff travel so justifies it have even matched the local boards for the cost of car-leasing services.

But there is much more that might be done. We could borrow a page from other agencies which provide portable libraries, blood donation centers, and chest X-ray screening. For example, I like this suggestion from one of our state hospital administrators:

> . . . Have an open van constructed with suitable windows, lighting, carpeting, etc., that would establish a route for picking up students. The students would be brought to central pick up points by the parents, but this would require only a matter of a few miles of driving. The bus could make a circle route that would entail, for example, four hours from beginning to end so that each student would be on the bus for a full four hour period. Activities would then be conducted while the bus

was enroute. Provisions could be made for stops enroute for such things as nature study, observation of various community activities, or other activities that community might permit. The traveling classroom could then take a second route for the afternoon four hours for a second group or, of course, the full day could be spent with one group, depending upon needs and circumstances.

The project could be called "LSD trip" -- (Local Services Demonstration). If you like, I'll let you borrow my "pipe 'n pot" so you can fully appreciate the ramifications of this suggestion.

Another method of counteracting the distance effect could be a weekday boarding system. The idea is that the consumer would not drive back and forth each day to the service center, but would drive in once on Monday morning and back on Friday afternoon. On the other nights he could stay at the center itself or board with a family in town. There are many models for this pattern all over the world and throughout our history.[13] But two facts must be remembered: (1) an off-beat provision for boarding costs may be the key to the whole program, and (2) it is going to cost.

Returning to transportation as such, I refer you to an excellent paper by Hodges and Dorken entitled "Location and Outpatient Psychiatric Care."[14]

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[13] The Norwegians maintain, at least in Oslo, a facility known as Sykehotell, where out of town visitors coming for medical or health purposes may stay. In typical Scandinavian style, it is run by a non-profit corporation but heavily subsidized by the state. An example from private enterprise is the vast array of boarding facilities in Rochester, Minnesota, for the benefit of visitors to the Mayo Clinic, ranging from posh hotels on down to higgledy-piggledy rooming houses. Rochester is sometimes referred to as "American medicine's answer to Atlantic City."

[14] Hodges and Dorken (see bibliography).

This is short but very sound, and documents the finding that an hour's drive is about the outer distance limit for consistent and regular use of the center service; that is, beyond this distance, consumer use and attendance fall off markedly. The authors also admonish: "When community services as distinguished from clinical services -- for example, consultation to agencies, provision of inservice training programs, and education of the public -- are to be the major aspects of a program, distance and location become even more important considerations in planning."[15]

I hope this conference can obtain some clear understanding on federal rules in relation to transportation costs and that in this context we might devise specific transportation models.

(2) Communications

Everything I have said about transportation could be echoed in regard to communications. I think there is much that might be done with closed-circuit television in rural areas, as Wittson and others have shown. There are no doubt in the field of telephonic and electronic gadgetry many other possibilities for mental health-mental retardation program enhancement. A related program issue is the need for an effective information system, which in Minnesota we have come to regard as vital.

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[15] Ibid, p. 241

(3) Manpower

This is a more basic concern than transportation and communications for without adequate manpower there can be no program.

We all know about the manpower problem, and there seems to be little point in trying to review all the facts of the problem or bemoaning it. It is going to keep on getting worse, especially in the rural areas. As if things were not already bad enough, the draft will add to our woes.

But it is easy to cry poormouth and not look at some of the things that might be done within the limits of the manpower problem.

In the first place we have to look at the professions and their standards and see to what extent the standards really match the jobs that need to be done. Stated another way, are there methods of utilizing persons of lesser professional status for certain portions of programs? Of course there are, and we all know it. There are multiple uses for paid and unpaid nonprofessionals in a variety of fields: doing certain forms of casework services, for example; chauffeuring; providing home health services; administering and scoring pen-and-pencil psychological tests; etc. The main problem in this area that I see, aside from lack of creative imagination that may afflict any of us when we are in the doldrums, is the rigidity and institutionalization that afflicts the professional societies when manpower innovations occur that seem to threaten the status quo. Examples from Minnesota history are the famous reactions to our move to turn state hospital management functions over to non-medical hospital administrators, and a more

Ramsey, and St. Louis Counties) a total of 638 professional (i.e., non-clerical) employees. That is a pretty solid group of personnel; not enough maybe to serve a general population of 1.5 million or more, but not bad. To be sure, only one in 25 of these employees have a master's degree (as contrasted with one in 12 in the urban counties). One is almost tempted to say, So what?

Academia has contributed little in this situation. Typically the universities criticize public agencies as being riddled with non-professionalism, but do very little to extend themselves to improve quality of work performance on the job or to provide training in segments; rather they tend to require that the person come in off the job for a full shot of training en bloc, which relatively few people can afford.

The A.P.A. statistics show that the Rocky Mountain states have a relatively low concentration of psychiatrists per 100,000 population. Again, one is tempted to say, So what? What can we say about the hard impact that this will have on the quality of life in those locations? There are nations that have a bare handful, one, or even no psychiatrists for millions of people. Is life in the Rocky Mountain states going to be any the less beautiful or rewarding, the more fraught with experiments perilous or decisions difficult because there is a low concentration of psychiatrists? Again, the answer may be not in manpower ratios but in programs, which are not the same thing; and the few psychiatrists can enjoy to the fullest the high value and impact of their work.

After 16 years in the business I have become weary of the manpower shibboleth. My feelings have been reinforced strongly by my experience as a citizen in viewing the military buildup in Vietnam. It is too easy for organizations and populations to blame their failures on insufficient manpower. A beautiful illustration of this process is found in William Ryan's monograph Distress in the City, a study of mental health programs in Boston, which shows that even in the face of what might be called an abundance even an excess of professional manpower, the programs still get done dirty by the service model, in the absence of overall program design and coordination. In Boston as well as Pocatello they are yelling for more staff.

The work of Kiesler, Muhich, Hunter, Robert Williams and many others in Minnesota in my view proves conclusively that a small number of mental health-mental retardation professionals can accentuate their impact to a fantastic degree by adapting their style to the realities of the situation, by holding back on directly providing the services themselves and instead concentrating their efforts toward improving the service-providing skills of others. Nothing I have said should be construed as advocating amateurism. The fact is that amateurs can be helped to develop a considerable range of know-how and adeptness in the discharge of mental health-mental retardation duties. From this point of view our 600 non-masters' degree social workers in the rural welfare agencies in Minnesota are a mighty army whose talents and skills as human beings can be developed and utilized. And I would venture to guess that there are similar armies in other rural states if the planners and executives will make the effort to use them.

Not only must we bend the rigid protocols of the professional societies, not only must we learn how to convey our skills to others, but we must change our habits. This means leaving offices and getting out to the store fronts and Grange Halls and parish houses. It means learning how to communicate with the sheriffs and judges and county attorneys and public health nurses, hospital administrators, ministers, bartenders, and political leaders. For they are the ones who meet the action where and when it happens.

Here is a nice anti-poormouth statement from one of our mental health-mental retardation experts in Minnesota, serving an area with a population density of around 10 pers./sq.mi.:

> . . . It can be understood without deep thinking that distance is a factor in establishment, delivery, and cost of services. It goes without deep thinking that manpower problems are different in remote areas. This is why the people in Australia, South America, North America, Africa and other underdeveloped areas get extremely excited when we talk of using existing resources. This is the most hopeful real alternative that they have seen. I wish you could have been with me in Mexico City recently to see the faces of people when we talked about our use of local police and nurses as mental health agents.
>
> To the extent of my knowledge, there is nothing in the NIMH regulations that prevents a person from going ahead and tailoring a program to sparsely populated rural areas. We have not had any hang-ups here in an area of 10,000 square miles, 100,000 people.
>
> I don't believe there is any point in going into the manpower question here. You know and have at least tacitly supported our policy of hiring a few super-consultants, paying them super-salaries as necessary, and not trying to hire a therapist for every nervous cat in the territory.
>
> As I reflect again on these points, it seems almost silly that the people focus on distance and transportation cost and rural attitudes. All of these things have existed in the rural area before the mental health people got there. The people are used to distance, getting to places, or people getting to them. I believe firmly that it is up to the mental healthers to tailor their thinking

> to the existing rural conditions. One of the finest factors in beginning or reorienting a program in a rural area is the pride of the people combined with their frontier interdependence. When you say 'we can take care of our own' or 'you can go to a neighbor for help' or 'your neighbor can help you in a pinch,' these people know what you are talking about. They don't insist on the man with twenty-five years of education to lean on during a rough period.

One will have to admit that there are problems attending the circuit-riding of specialists around the "territory," or the importation of super-specialists at a high price. But there is ample experience on these points; the problems are known and can be anticipated and resolved.

IV. Culture

This is in many respects the most interesting problem of all. What is the quality of life in rural America? What are the attitudes that prevail? How do these affect the genesis, the recognition, and the resolution of mental health-mental retardation problems? These are matters for the sociologists and anthropologists to engage with, the philosophers and politicians, the poets and novelists and sweet singers. We are abundantly gifted in our national heritage with many very beautiful and sensitive views of country life.

Out of the enormous range of sources, I will quote from two that may convey the loneliness, the possibility for sorrow that exists in American rural life. One is now relatively old, one is new, but both are blue. I hope they are relevant to the theme of this conference.

First, the paragraphs from the opening pages of The Wonderful Wizard of Oz, by L. Frank Baum:[16]

> When Dorothy stood in the doorway and looked around, she could see nothing but the great gray prairie on every side. Not a tree nor a house broke the broad sweep of flat country that reached the edge of the sky in all directions. The sun had baked the plowed land into a gray mass, with little cracks running through it. Even the grass was not green, for the sun had burned the tops of the long blades until they were the same gray color to be seen everywhere. Once the house had been painted, but the sun blistered the paint and the rains washed it away, and now the house was as dull and gray as everything else.
>
> When Aunt Em came there to live she was a young, pretty wife. The sun and wind had changed her, too. They had taken the sparkle from her eyes and left them a sober gray; they had taken the red from her cheeks and lips, and they were gray also. She was thin and gaunt, and never smiled, now. When Dorothy, who was an orphan, first came to her, Aunt Em had been so startled by the child's laughter that she would scream and press her hand upon her heart whenever Dorothy's merry voice reached her ears; and she still looked at the little girl with wonder that she could find anything to laugh at.
>
> Uncle Henry never laughed. He worked hard from morning till night and did not know what joy was. He was gray also, from his long beard to his rough boots, and he looked stern and solemn, and rarely spoke. 17

Second, a statement from a Department of Public Welfare staff member, an old hand in the welfare business, in response to the thesis "Attitudes in rural areas are different from urban areas":

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16 Baum, L. F. (see bibliography)

17 Op.Cit., pp. 12-13

> I think the rural person may be more prone to think of his mentally ill or retarded child as born 'queer.' This then must certainly be due to some 'sin' or fault of the parent -- 'God's Visitation.' If the child is like this -- it is meant to be. What is God's Will is final. This limits the child's chances for education and training up to his potential. He is apt to be relegated to the rear instead of the foreground in the family Constellation and catches many of the jobs of drudgery. This situation is loaded with many guilt feelings, of course. Actual neighborhood training and treatment facilities are at a minimum or nil; this adds to the feeling of general futility and pessimism.
>
> But you know the above concept better than I.

These comments may strike you as pessimistic, but I think they capture something profound, essential and irreducible in American life.

Another of our Department of Public Welfare workers has a different slant:

> Attitudes probably are not essentially different; in a rural area the sample is apt to be proportionately broader. The population in rural areas I believe is more apt to be better integrated across income levels in contrast to the income and other segregating elements found in the urban areas . . . I would suggest that the attitudes, prerogatives, and jealousies are more widely known in the rural areas and a thinner veneer of disguise exists. This would make them stand out.

A personal observation. In the fall of 1967 the staff of the Medical Services Division of the Department of Public Welfare conducted a series of regional conferences throughout the state to discuss a new mental hospitalization and commitment law which was to go into effect on January 1, 1968. The meetings involved judges, sheriffs, county attorneys, county welfare directors and caseworkers, community mental health center and mental hospital personnel and others. I was impressed and depressed by the

consummate amount of poormouthing that we heard in the rural regions -- the frequent complaints that "This is impossible for us in the country" and "This is a law designed for the urban areas," etc. Basic to the complaint were themes of expense and manpower shortages. But it was pointed out to me by one of our staff members, J. T. Sarazin, that the counterpart or reverse problem in the urban area is the large size, prestige, and institutionalization of the involved agencies. In many ways this fact can make what James Reston has called "the courageous and flexible use of cooperative intelligence" a much more difficult process in the city, where there are so to speak more moving parts to go out of order and many more clearances that are necessary for things to get done. The relative case of face-to-face communications among a handful of persons in the country can be a powerful factor in program development and implementation (though it must be added that chumminess and the buddy system can impede the orderly working-out of agreements). The experience in Minnesota has been that the implementation of the new law has progressed favorably, at least as well in the rural as in the urban areas.

When in doubt on community mental health matters, consult Gerald Caplan. His sayings and writings are exquisitely lucid and to the point. Relevant to our theme here is what Caplan designates, among the "population-oriented models" of community mental health programs, as the "metabolic or nutritional model."[18]

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[18] Caplan, G. (see bibliography)

Thus: "The moulding of growth and development of individuals in a population can be seen as a reaction to the provision of supplies."[19] Among these he lists psychosocial supplies, the opportunity for meaningful interpersonal relationships; and sociocultural supplies, ". . . a stable societal structure which provide a range of social, occupational, and religious roles, so that all members of the population may find places which suit their needs and capacities."[20]

These ideas have an immense and powerful application to the problems of mental health-mental retardation programming in rural areas. We mental health-mental retardation professionals should be attending to the supplies, doing our part to see that they are provided. Not just professional manpower supplies, but the other supplies of which Caplan speaks: the chance for interpersonal relationships, stability, legitimate roles, and a comfortable place for every person, "in an environment which contributes positively to healthful individual and family living." (As P.L.89-749 states.)

V. Overriding concerns

The theme of this conference in some ways is as old as capitalism, maybe even older. For with the elaboration and refinement of manufacture and

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[19] Op. Cit., p. 8

[20] Ibid, p. 8

bureaucracy has come a depopulation of the countryside, a breakdown of the old feudal and later freeholding systems. The problem of manpower shortages and the complaint that "city folks don't understand" in my opinion go back to this basic and inexorable process in industrial life.

Here is what Oliver Goldsmith said in the eighteenth century:

> These were thy charms, sweet village; sports like these,
> With sweet succession, taught even toil to please;
> These round thy bowers their chearful influence shed.
> These were thy charms -- But all these charms are fled.
> Sweet smiling village, loveliest of the law,
> Thy sports are fled, and all thy charms withdrawn;
> Amidst thy bowers the tyrant's hand is seen,
> And desolation saddens all thy green:
> One only master grasps the whole domain,
> And half a tillage stints thy smiling plain;
> No more thy glassy brook reflects the day,
> But choaked with sedges, works its weedy way;
> Along thy glades, a solitary guest,
> The hollow-sounding bittern guards its nest;
> Amidst thy desert walks the lapwing flies,
> And tires their ecchoes with unvaried cries.
> Sunk are thy bowers, in shapeless ruin all,
> And the long grass o'ertops the mouldering wall;
> And, trembling, shrinking from the spoiler's hand,
> Far, far away, thy children leave the land.
> Ill fares the land, to hastening ills a prey,
> Where wealth accumulates, and men decay:
> Princes and lords may flourish, or may fade;
> A breath can make them, as a breath has made;
> But a bold peasantry, their country's pride,
> When once destroyed, can never be supplied.

In my research on this paper, I was started to find these comments on the subject of rural depopulation (emphasis added):[21]

> In all countries of the world during the first half of the 20th century there was a trend from the countryside to the town; even in countries where the rural population was increasing, the urban

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[21] Encyclopedia Brittanica, 1957 edition, volume 19, section on Rural Depopulation.

> population was increasing at a greater rate, so that practically everywhere the proportion of the rural to the total population was decreasing. 22

and

> Where population becomes thinly spread it is difficult, sometimes impossible, to maintain the social structure of the community and the social services which have been built up. 23

Finally,

> There is a growing appreciation all over the world that the problems raised by rural depopulation, with the consequent drift to towns and urban overcrowding, cannot be solved apart from a comprehensive policy of national planning. 24

We are no longer in the age of Oliver Goldsmith or L. Frank Baum. We are in a post-industrial society. This is an age in which all things are possible. Are we ready for a "comprehensive policy of national planning"? Only time and the great processes of political self-determination will tell.

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[22] Op. Cit., p. 669

[23] Ibid, p. 670

[24] Ibid, p. 670

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PERSONAL COMMUNICATIONS

The following persons were kind enough to give me very interesting and helpful suggestions on the theme of mental health and mental retardation programs in rural areas. If I have omitted anyone inadvertently, I apologize.

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